STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	02/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00104024. Complaint IN00104024- Unsubstantiated due to a lack of evidence. Survey dates: February 13, 14, 15, 16, 17, and 22, 2012 Facility Number: 010739 Provider Number: 155764 AIM Number: N/A Survey Team: Regina Sanders, RN, TC Marcia Mital, RN Kelly Sizemore, RN Sheila Sizemore, RN Census bed type: SNF: 48 Residential: 71 Total: 119 Census Payor Type: Medicare: 40 Other: 79 Total: 119 Sample: 12	F0000	The submission of this plan of correction does not indicate an admission by Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus . This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities.(for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Supplemental sample: 6 Residential Sample: 7 Residential Supplemental Sample: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on February 27, 2012 by Bev Faulkner, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify a resident's physician of the need for a clarification of an order for 1 of 12 residents in a sample of 12 residents reviewed for physician	F0157	1. Resident #19 physician was notified at the time of survey for clarification of orders. Order clarified for 4200 units. 2. All residents have the potential to be affected by this deficiency .	03/23/2012

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	notification. (Resident #19) Findings include: 1. Resident #19's record was reviewed on 2/14/12 at 2:30 p.m. Resident #19's diagnoses included, but were not limited to, dementia, hypothyroidism, and coronary artery disease. The resident's admission physician's orders, dated 2/10/12, indicated pancrelipase (an enzyme to aid with food digestion) 50 milligrams per peg tube three times a day. The resident's MAR (Medication Administration Record), dated 2/12, indicated the pancrelipase had not been administered 2/10/12 through 2/14/12. The back of the MAR indicated the medication was not available on 2/11/12 and 2/13/12. On 2/13/12 documentation also indicated "awaiting...clarification." A fax to the physician, dated 2/13/12 at 2:40 p.m., indicated "...also on (Resident #19's name) her pancrelipase does come in 50 mg (milligram) dose, they said that's too low." The resident's nurses' notes dated 2/10/12 through 2/14/12 lacked documentation to indicate the physician had been notified		Orders of other residents were reviewed with no other residents found to be affected by this deficiency. 3. The deficiency was evaluated relative to system, education and compliance. In-servicing for licensed staff will be conducted by the DHS/ designee by 3/23/12 regarding the importance of timely follow up related to pharmacy request to clarify orders. 4. The DHS /designee will audit physicians orders for the need to clarify and timely notification weekly times 4 , monthly times 5 (see attachment A) . Results from audits will be reviewed by the DHS/designee and forwarded to the QA committee with audits continued if required until 100% compliance is met. Compliance date : 3/23/12	

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	the order needed to be clarified. During an interview on 2/14/12 at 2:45 p.m., LPN #111 indicated the physician should have been notified to clarify the order right away after the pharmacy notified them of the need for a different dosage. During an interview on 2/14/12 at 3:35 p.m., LPN #111 indicated she had clarified the dosage for the pancreilapse. She indicated the order was for 4200 units. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Based on record review and interview, the facility failed to ensure resident's discharge instructions were complete related to medications, laboratory tests, and diagnostic tests for 2 of 6 residents reviewed for transfer and discharge orders in a sample of 12. (Residents #12 and #122) Findings include: 1. Resident #122's closed record was reviewed on 2/15/12 at 2:25 p.m. Resident #122's diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation, and history of pulmonary embolism. The resident's admission physician's orders, dated 1/5/12, indicated the resident was to have blood sugar checks before meals and bedtime and administer Novolog (insulin) per a sliding scale (amount of insulin administered was dependent upon the resident's blood sugar results.) The sliding scale indicated: 70-150 = 0 insulin 151-200 = 2 units	F0204	1. Resident # 122 was contacted by the DHS to discuss discharge instructions. No negative outcomes noted . Physician was notified at the time of survey. Resident # 12 Physician was notified at the time of the survey . Lab values were within normal limits. Physician did not want to continue potassium. No negative outcomes. 2. Records were reviewed for discharged residents during the past 14 days to ensure complete discharge instructions were provided. No other residents were found to be affected by this deficiency. All residents have the potential to be affected by this deficiency. 3. This deficiency was evaluated relative to system , education and compliance. In servicing for licensed staff will be conducted regarding preparing appropriate discharge instructions by the DHS/designee by 3/23/12. 4. The UM /designee will audit the Discharge Instructions for accuracy on the day of discharge for all discharged residents (see attachment b). The DHS /designee will receive a copy of the d/c instructions for review. Results will be presented for 6 months to the monthly QA	03/23/2012

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	201-250 = 4 units 251-300 = 6 units 301-350 = 8 units 351-400 = 10 units. Over 400 = 12 units and call MD. A physician's order, dated 1/9/12, indicated "Start 3 mg (milligrams) coumadin po (orally) QD (every day) on 1/10/12. recheck (PT/INR a test for blood clotting times) 1/13/12." A physician's order, dated 1/10/12, indicated "May have colonscopy (diagnostic test for bowels) per res (residents) request." A physician's order, dated 1/12/12, indicated "Ok to discharge to home- on 1/12/12. Send 3 days of meds (medications) with resident." The resident's "Discharge Summary", dated 1/12/12, indicated a lack of documentation of the resident's blood sugar test, the sliding scale, and the laboratory test of the PT/INR ordered to be drawn on 1/13/12, or any information related to the colonoscopy. During an interview on 2/15/12 at 2:55 p.m., the ADoN (Assistant Director of Nurses) indicated the resident's discharge instructions lacked documentation of the		Committee meeting.	

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	blood sugar checks and sliding scale insulin orders, the PT/INR laboratory test ordered to be drawn on 1/13/12 and any follow up on the colonoscopy. 2. Resident #12's record was reviewed on 02/14/12 at 2:20 p.m. The resident's diagnoses included, but were not limited to, hypertension and depression. A physician's order, dated 01/31/12 at 3:45 p.m., indicated an order for potassium 20 meq (milliequivalents) daily. A physician's order, dated 02/03/12 at 4:30 p.m., indicated an order to send the resident to the hospital for a direct admission. The transfer forms, lacked documentation to indicate the resident had an order for potassium 20 meq. During an interview on 02/14/12 at 3:30 p.m., the Director of Nursing indicated the transfer forms did not indicate the resident had an order for potassium 20 meq. 3.1-12(a)(21)			

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F0226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to implement the facility's policy for the Elder Justice Act and train their employees related to the facility's policy and procedure for reporting suspected crimes under the federal Elder Justice Act for all employees. (Employees #1 through #133) Findings include: During an interview on 2/14/12 at 4:47 p.m., the Administrator, indicated the facility's employees had not been trained or inserviced on the Elder Justice Act. The Administrator indicated the facility had only inserviced the employees on the facility's abuse policy. The facility's policy and procedures for "Reporting Crimes Pursuant to the Elder Justice Act," dated August 2011, indicated "The purpose of this policy is to outline how Trilogy Health Services...will comply with the legal requirements that it notify certain individuals of their duty to report crimes to the Secretary of the	F0226	1. The facility implemented the policy on the Elderly Justice Act during the survey for all employees. No negative outcomes were identified. 2. All residents are at risk for the alleged deficiency . No negative outcomes have been identified. 3. The deficiency was evaluated relative to system , education and compliance . In-servicing on Abuse/Elder Justice Act will be part of the orientation on-boarding process and annual in-service calendar. 4. Human resources/designee will keep a record of all employees who require in-servicing on Abuse/Elderly Justice Act (see attachment C) and monitor compliance. Compliance date : 3/23/12	03/23/2012

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	Department of Health and Human Services and to local law enforcement....Policy It is Trilogy's policy to notify owners, operators, employees, managers, agents, and contractors...of their duty to report reasonable suspicions of crimes to the Secretary and local law enforcement...Trilogy shall implement the above policy as follows:.. Determine Applicability...2. Notification of Duty to Report...Trilogy shall take steps to ensure that Covered Individuals are notified annually of their duties to report under the Social Security Act....3. Notification of Duty to Report...4. Non-Retaliation...5. Reporting to the Secretary...6. Reporting to Law Enforcement on Behalf of Covered Individuals...7. Interview by Law Enforcement During an interview on 2/17/12 at 12:30 p.m., the Administrator indicated the facility had started training the employees on the Elder Justice Act. 3.1-38(a)			

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F0243 SS=C	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. Based on record review and interview, the facility failed to offer the residents an opportunity to establish and meet in resident groups for 4 of 4 residents who attended the group interview, this had the potential to affect 48 of 48 residents residing in the facility. (#1, #11, #23, and #39) Findings include: During the group meting held on 2/14/12 at 3:00 p.m., four of four residents, who attended the group interview, Residents #1, #11, #23, and #39, indicated they do not meet on a routine or regular basis. The residents indicated they had never been invited to a Resident Council Meeting. During an interview on 2/14/12 at 4:05 p.m., with the Administrator, Acting	F0243	1. A resident council meeting was conducted at time of survey . No negative outcomes were noted. 2. All residents have the potential to be affected by this deficiency. 3. The deficiency was evaluated relative to system education and compliance. In servicing for the Activity Director and Social Service Director on requirements for resident council meeting was conducted by Resident Activity Support on 3/23/12. Resident council meetings will be added to the activity calendar monthly to advise the residents of the date and time of the meeting. 4. The Executive Director will monitor that Resident Council meetings are being held monthly (see attachment D). Compliance date : 3/23/12	03/23/2012

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	Activity Director, and the Corporation Activity Support Person. The Corporation Activity Support Person indicated she could not find evidence of the residents having a resident council meeting. She indicated the only meetings she could find were for the assisted living and she was "trying to get things back in place." The Administrator indicated once the facility gets a new Activity Director in place the resident council meeting will be started. 3.1-3(g)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. A. Based on observation, record review, and interview, the facility failed to ensure physician's orders were followed related to geri sleeves for 1 of 12 residents in a sample of 12. (Residents #37) B. Based on observation, record review, and interview, the facility failed to ensure qualified staff administered oxygen for 2 of 5 residents with oxygen in a sample of 12 residents. (Residents #3 and #37), related to CNAs adjusting oxygen flow rates. (CNA #50 and #91) Findings include: A.1. Resident #37's record was reviewed on 2/13/12 at 12:50 p.m. Resident #37's diagnoses included, but were not limited to, hypothyroidism and hypertension. Resident #37's admission physician's orders, dated 12/24/11, indicated geri-sleeves to bilateral upper extremities at all times. A care plan, dated 12/31/11, indicated the	F0282	1. Residents #37 Geri sleeves were donned during the time of the survey. Resident is being monitored during daily rounds to ensure geri sleeves are in place. Resident #37 and #3 have had their O2 settings corrected to reflect physician orders of 3L. 2. Residents with Geri sleeve and O2 orders were reviewed to ensure correct placement and O2 liter flow. 3. The deficiency was evaluated relative to systems , education and compliance . In-servicing for staff will be conducted by the DHS/designee by 3/23/12 on facility guidelines for following MD orders. Nursing assistants will be in-serviced by the DHS/designee regarding scope of practice with regards to administration of oxygen. 4. Nursing leaders/designee will monitor O2 settings and placement of Geri-sleeves during daily rounds for 4 weeks, biweekly for 4 weeks, weekly for 4 weeks. Audits will include all shifts. Results from audits will be reviewed by the DHS/designee and forwarded to the QA committee with audits expanded if required until 100% compliance is met.	03/23/2012

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	resident had a skin tear and an abrasion. The resident's skilled nursing assessments (daily Nurses' Notes), dated 12/29/11, 01/04/12, 01/05/12, 01/06/11, 01/11/12, 01/12/12, and 01/25/12, indicated the resident had a skin tear and/or a bruise. The form lacked documentation of the area of the bruise/skin tear. Resident #37 was observed sitting in his wheelchair, on 2/13/12 at 12:20 p.m., 12:40 p.m., 1:22 p.m., and 1:26 p.m., without any geri-sleeves on his arms. Resident #37 was observed on 2/14/12 at 9:35 a.m., sitting in his wheelchair; 10:40 a.m. lying in bed, and 12:50 p.m., sitting in his wheelchair without any geri-sleeves on his arms. During an interview on 2/14/12 at 10:40 a.m., LPN #111 indicated the resident did not have on geri-sleeves. B. 1. Resident #3 was observed up in her wheelchair in the dining room on 2/13/12 at 1:05 p.m. The resident's oxygen level was set at two liters. The resident's daughter indicated the CNA had placed the resident's oxygen on when getting her up. LPN #30 indicated the resident's oxygen should have been set at three liters. The resident's daughter was			

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	observed to turn the resident's oxygen to three liters. During an interview on 2/13/12 at 1:10 p.m., CNA #91 indicated she had gotten the resident up and into her wheelchair. CNA #91 indicated she had turned the resident's oxygen on. Resident #3's record was reviewed on 2/14/12 at 11:30 a.m. Resident #3's diagnoses included, but were not limited to, congestive heart failure, hypertension, and pacemaker. A physician's order, dated 2/2/12 indicated the resident was to receive three liters of oxygen continuously. B. 2. Resident #37's record was reviewed on 2/13/12 at 12:50 p.m. Resident #37's diagnoses included, but were not limited to, hypothyroidism and hypertension. Resident #37's physician order recapitulation, dated 1/12, indicated oxygen continuously at 3 liters per minute. Resident #37 was observed on 2/15/12 at 12:00 p.m., with his oxygen on 2 liters. During an interview on 2/15/12 at 12:15 p.m., RN #124 indicated the resident's			

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	155764	A. BUILDING 00 B. WING	02/22/2012

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	oxygen should have been on 3 liters. She indicated the CNA probably set the flow rate for the oxygen when she got the resident up. During an interview on 2/15/12 at 2 p.m., CNA #50 indicated she had set the resident's oxygen on 2 liters. She indicated her CNA assignment sheet indicated the resident's oxygen was supposed to be on 2 liters. An undated facility policy, provided by the Administrator on 2/15/12 at 9:40 a.m., titled "Guidelines for Administration of Oxygen" indicated "Purpose: To provide guidelines for safe oxygen administration when insufficient oxygen is being carried by the blood to the tissues...." 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to assess and treat residents with edema and a skin tear for 2 residents in a sample of 12 residents reviewed for the necessary care and treatment in a total sample of 12. (Residents #20 and #38) Findings include: 1. Resident #20's record was reviewed on 2/15/12 at 11 a.m. Resident #20's diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, and arthritis. The resident's Skilled Nursing Assessment and Data Collection forms, dated 1/29/12 through 2/2/12, on the 7-3 shift indicated the resident did not have any edema. A Change in Condition Form, dated 2/2/12 at 1:10 p.m., indicated "...DTR (daughter) brought to writers attention	F0309	1. Residents #20 was assessed during the time of the survey. Physician was notified. Orders were received and carried out. . Resident #38 was assessed during the time of survey . Physician was notified. Orders received to d/c treatment as area was healed. No negative outcomes were noted . 2. Current residents will be assessed to determine if they have edema. Residents with skin issues requiring a dressing change will be reviewed to verify compliance with physician order. 3. The deficiency was evaluated relative to systems , education and compliance . In servicing for licensed staff will be conducted by the DHS/designee by 3/23/12 on facility guidelines for nursing assessments, change of condition and compliance with physician orders for dressing change . 4. The DHS /designee will audit change of condition during stand up meeting weekly times 4 (see attachment A) . Rounds will be made daily to verify compliance with dressing change orders times 4 weeks	03/23/2012

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	swollen bil (bilateral) legs, is on lasix (diuretic medication)...Dtr states 'It's been like this for a few days & I've mentioned it to a couple people.' I appoligized (sic) & paged MD...Physician order...low sodium diet, zaroxlyn (a diuretic) 5 mg (milligrams)... x (times) 7 days..." During an interview on 2/15/12 at 12:15 p.m., RN #124 indicated the nurses' should have been assessing the resident for edema and gotten a treatment. 2. Resident #38's record was reviewed on 2/15/12 at 11:37 a.m. Resident #38's diagnoses included, but were not limited to, Parkinson's disease, arthritis, and hypothyroidism. A Skin Impairment Circumstance, Assessment and Intervention form, dated 2/8/12, indicated the resident had a skin tear to the left wrist and a treatment was implemented. A physician's order, dated 2/8/12, indicated cleanse left wrist with wound wash, apply bacitracin and cover with bandaid twice a day. Resident #38 was observed on 2/15/12 at 11:35 a.m. with a dressing on her left wrist dated 2/12/12. A TAR (Treatment Administration		then weekly times 4 weeks. Results from audits will be reviewed by the DHS/designee and forwarded to the QA committee with audits expanded if required until 100% compliance is achieved. Compliance date : 3/23/12	

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	Record) for February 2012, indicated cleanse left wrist with wound wash, apply bacitracin and cover with bandaid twice a day. The initial treatment done on 2/8/12 on the 3-11 shift. The treatment was initialed was done twice a day 2/9/12 through 2/13/12. On 2/14 on the 7-3 shift, the initials were circled (indicating the treatment was not done). There lacked documentation on the back as to why the treatment was not done. During an observation on 2/15/12 at 2:30 p.m., Resident #38's dressing to the left wrist was dated 2/12/12. During an interview on 2/15/12 at 2:33 p.m. with RN #124, she indicated the treatment was not done as ordered. She indicated she did not know why the staff had initialed the treatment had been done on 2/13 on the 7-3 and 3-11 shift due to the date written on the dressing. 3.1-37(a)			

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F0325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review, and interview, the facility failed to ensure residents' maintained acceptable parameters of nutrition and follow up on the Registered Dietician's (RD) recommendations to prevent weight loss for 3 of 3 resident's with significant weight loss (Residents #9, #20, and #37) and failed to re-weigh a resident per the RD recommendations for 1 of 1 closed records reviewed in a total sample of 12. (Resident #122) Findings include: 1. Resident #37's record was reviewed on 2/13/12 at 12:50 p.m. Resident #37's diagnoses included, but were not limited to, hypothyroidism and hypertension. The resident's recapitulation orders, dated 02/12, indicated an order for Lasix (diuretic) 20 milligrams daily, originally	F0325	1. Resident #37's physician was notified of weight loss and RD recommendations. Orders were received for RD recommendations. Resident # 20's physician was notified of the resident's weight discrepancy and failure to provide dietary supplement as ordered. MAR will be corrected to reflect correct physician order. Resident #9's physician was notified of the resident's weight loss and failure to provide the ordered diet. The tray card will be updated to reflect the correct diet. #122 (resident no longer at this facility) The above residents will be weighed monthly per campus policy or per physician orders. Weight loss of >5% within 30 days will be re-weighed to ensure weight accuracy. Physician will be notified if weight loss has been verified as accurate. 2. Current month weights will be reviewed with re-weighs obtained as applicable. RD recommendations for the past 30 days will be	03/23/2012

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	ordered on 12/24/11 and Synthroid (thyroid medication) 125 microgram, originally ordered on 12/26/11. An admission MDS (minimum data set) assessment, dated 12/31/11, indicated the resident's cognition was moderately impaired. The resident had not had any weight loss and his weight was 150.1 pounds. The resident's admission assessment, dated 12/24/11, indicated the resident's weight was 150 pounds. A care plan, dated 1/6/12, indicated "Resident at nutritional risk...leaves 25% or more food uneaten at most meals...interventions...Provide/monitor intake of diet/fluids...offer substitutes if 50% or less is consumed...weigh and monitor results..." During an interview on 2/14/12 at 10:12 a.m., RN #124 indicated residents were weighed on admission and then in 2 weeks and then monthly. She indicated Resident #37 had not been weighed like he was supposed to be; two weeks after admission and then monthly. She indicated the resident's weight on 1/4/12 was 137 pounds. (This was a 8.6 percent weight loss in 11 days.)		reviewed to ensure physician notification and implementation of orders. Physicians and families will be notified as appropriate. 3. The deficiency was evaluated relative to systems , education and compliance . In-servicing for staff will be conducted by DHS/ designee on facility guidelines on following dietary recommendations, physician notification, obtaining weights and re-weighs per policy, and providing the correct diets and supplements per physician orders.. 4. . The DHS/RD or designee will monitor weights, follow through with physician notification for RD recommendations and provision of ordered diets and supplements weekly times 4 weeks, bimonthly times 4 weeks. Results from audits will be reviewed by the DHS/designee and forwarded to the QA committee with audits expanded if required until 100% compliance is achieved. Compliance date : 3/23/12	

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	The dietary intake records, dated 01/02/12 through 01/31/12, indicated the resident's breakfast consumption was 15-100%, with no breakfast intake documented for 01/22/12 and 01/24/12. The dietary intake records, dated 01/02/12 through 01/31/12, indicated the resident's lunch consumption was 60-100%, with no lunch intake documentation for 01/22/12 and 01/24/12. The dietary intake records, dated 01/02/12 through 01/31/12, indicated the resident's dinner consumption was 75-100%, with no dinner consumption documented for 01/06/12 and 01/30/12. A Nutrition Assessment and Data Collection form completed by the RD, dated 1/4/12 at 3:45 p.m., indicated the resident's weight on admission was 150.1 pounds. The resident's diet order was mechanical soft. The supplemental nutrition was 25 grams of whey protein powder daily. The assessment indicated "Resident receives mechanically altered food consistency d/t (due to) impaired dentation-' loose dentures.' Resident consumes < (less than) 75% of meals. Resident with increased (indicated with an arrow) nutritional needs...Receiving protein supplement but need for increased (indicated by an arrow) kcal (calories)			

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	increased (indicated by an arrow) protein. Recommend D/C (discontinue) whey protein powder and begin 90 ml (milliliters) Resource 2.0 tid (three times a day) between meals. Supplement will provide 540 kcals (calories)/22.5 gms (grams) protein/day. Monitor weight, oral intake...Weight may be affected by recent increase (indicated by an arrow) thyroid medication...." The resident's record lacked documentation to indicate the physician had been notified of the resident's weight loss or of the RD recommendations. A "Resident First Conference Notes", dated 1/11/12, indicated "...Nutrition weight stable..." A weight change report, indicated the resident's weight on 2/3/12 was 134.2 pounds. There was a lack of documentation of any other weights on the form.. There was a lack of any further documentation in the dietary notes related to the resident's weight loss. During an interview on 2/14/12 at 10:12 a.m., RN #124 indicated she thought the RD recommendations went to the DoN (Director of Nurses) and were supposed			

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	to be faxed to the physician for any new orders. She indicated she was unable to find any where anything had been done related to the resident's weight loss and the RD recommendations. During an interview on 2/14/12 at 11:50 a.m., the DoN indicated there should be documentation of the physician being notified of the RD recommendations either in the nurses' notes or an order if the physician had given a new order. During an interview on 2/14/12 at 11:54 a.m., the DoN indicated weights were done on admission and monthly unless the RD recommended weights be done more often. She indicated she was aware the resident had lost some weight but not how much. She indicated the resident had lost 3 pounds from January weight to February weight. She indicated she was going to contact the RD and see if she wants the resident on weekly weights. 2. Resident #20's record was reviewed on 2/15/12 at 11 a.m. Resident #20's diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, and arthritis. A care plan, dated 1/11/12, indicated "Resident at nutrition risk...leaves 25% or			

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	more of food uneaten at most meals...Interventions...Administer nutritional supplement as ordered...Provide/monitor intake...Weigh and monitor results..." A Nutrition Assessment and Data Collection form completed by the RD, dated 1/9/12 at 12:15 p.m., indicated the resident's weight on 1/6/12 upon admission to the facility was 163.8 pounds. The assessment indicated "...To met (sic) estimated nutritional needs recommend add 3 oz (ounce) Resource 2.0 tid (three times a day) between meals. Supplement will add 540 kcals/22.5 gms protein/day. If resident consumes supplements & 60% of meals expect nutritional needs to be met..." A physician's order, dated 1/19/12, indicated to start Resource 2.0, three ounces three times a day between meals. This was 10 days after the dietary recommendation had been made. The resident's January 2012, MAR (Medication Administration Record) indicated the Resource was to be given at 10:30 a.m., 2:00 p.m., and 8 p.m. The resident's February 2012, MAR indicated the Resource supplement was given at 10 a.m. and 2 p.m. The Resource			

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	was not given three times a day as ordered by the physician. A "Weight Change Report" indicated the resident's weight on 02/02/12 was 250 pounds and on 2/3/12 was 146 pounds. This was a greater than 10% weight loss in less than 1 month. There was a lack of documentation to indicate the residents weight had been obtained since 01/06/12 through 02/02/12. A change in condition form, dated 02/02/12 at 1:10 p.m., indicated the resident had edema of the bilateral lower legs, was had received 40 milligrams of Lasix twice a day. The resident's physician recapitulation orders, dated 02/12, indicated the resident had been receiving Lasix 40 milligrams twice a day since 01/07/12. There was a lack of documentation in the resident's record of any information of the resident's significant weight loss. During an interview on 2/15/12 at 12:01 p.m., the DoN indicated the only weight she had for the resident other than what was already in the chart was 250 pounds and then a re-weight on 2/3/12 of 146 pounds.			

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	During an interview on 2/15/12 at 12:35 p.m., RN #124 indicated she was not able to find anything in the resident's chart related to the weight loss. She indicated there was just the admission weight in the chart. She indicated they had received an order for Resource 2.0 to be given three times a day. 3. Resident #122's closed record was reviewed on 2/15/12 at 2:25 p.m. Resident #122's diagnoses included, but were not limited to, diabetes mellitus and morbid obesity. A Nutrition Assessment and Data Collection form completed by the RD, dated 1/9/12 at 1:30 p.m., indicated the resident's weight upon admission on 1/4/12 was 137.4 pounds. The assessment indicated "...Hospital records indicate hx (history) of morbid obesity-obtain re-weight as admit wt (weight) 137.4 # (pounds). Appears to be weight error..." A care plan, dated 1/11/12, indicated "Resident at nutrition risk...Interventions...Weigh and monitor results..." During an interview on 2/15/12 at 2:55 p.m., the ADoN (Assistant Director of Nurses) indicated she would check to see			

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	if she could find where a re-weight had been completed for the resident. During an interview on 2/16/12 at 12:25 p.m., the Corporate Nurse Consultant indicated they were not able to find anything related to the resident being re-weighed. An undated facility policy, titled "Guidelines for Weight Tracking" received, from the DoN as current on 2/15/12 at 9:40 a.m., indicated "...Residents will have their weight taken and recorded upon admission to establish a baseline...The facility dietician will review the resident's nutritional status, ideal body weight, and current weight to implement a nutritional program when warranted....Residents who have a weight that seems out of normal range shall be re-weighed to determine accuracy...The physician, responsible party and dietician shall be notified of a weight variance of > (greater than) 5%..." 4. Resident #9's record was reviewed on 2/15/12 at 11:30 a.m. Resident #9's diagnoses included, but were not limited to, dysphagia (difficulty swallowing), congestive heart failure, and hypertension. A Nursing Admission Assessment, dated 2/8/12, indicated Resident #9's weight was 96.8 pounds upon admission to the			

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	facility. The admission assessment indicated the resident required one assist for eating. The resident's admission orders, dated 02/08/12, indicated the resident had an order for Lasix 20 milligrams daily. A February 2011, physician's order, indicated the resident was to receive an Ensure Plus (supplement for low weight) three times a day. A Nutrition Assessment and Data Collection form, dated 2/8/12, indicated "...FLUID IMBALANCE RISK FACTORS: (checked yes) DIURETIC TX (treatment) EDEMA: (checked no)...Recommend d/c (discontinue) Ensure Plus...Begin 3oz (ounces) Resource 2.0 bid (twice a day) between meals...Monitor for signs/symptoms of increase fluid retention, monitor weight, oral intake, healing of incision, available labs...." There was a lack of documentation in the resident's record indicating the Ensure Plus had been discontinued and the Resource 2.0 started. There was a lack of documentation in the resident's record of any further weights on the resident. A physician's order, dated 2/10/12, indicated "Change diet to regular c/ (with)			

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	155764	A. BUILDING 00 B. WING	02/22/2012

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	nectar thick liquids. Strategies-cut into small pieces, small bites and sips. no straws, upright position during and 30 min (minutes) p/ (after) intake." The resident had been receiving a mechanical soft diet with nectar thick liquids. There was not a nutritional care plan for the resident documented in the resident's record. Resident #9 was observed on 2/14/12 at 5:47 p.m., receiving a mechanical soft diet with nectar thick liquids during the supper meal. The resident's family member indicated she had been telling the facility for four days the resident was supposed to be receiving a regular diet. The resident's dietary card indicated the resident was to receive a mechanical soft diet. During an interview on 2/15/12 at 11:50 p.m. CNA #90 indicated she had weighed Resident #9 on the scale and the resident weighed 89.4 pounds. CNA #90 indicated the weight she obtained for the resident was accurate. This was a 7.4 pound weight loss since 2/8/12. During an interview on 2/15/12 at 12:25 p.m., the Nurse Consultant indicated she had seen the weight and would tell the DoN (Director of Nursing). She indicated			

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	the resident's diet order should have been changed immediately. During an interview on 2/15/12 at 5:58 p.m., the DoN indicated the diet orders should have been changed immediately. An interview on 2/15/12 at 11:05 a.m., the Speech Therapist indicated she knew the family member was upset and told the family member if it happens again to come and see her. The Speech Therapist indicated the order for the diet was in the resident's chart. 3.1-46(a)(1) 3.1-46(a)(2)			

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F0328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, record review, and interview, the facility failed to ensure physician's orders were followed related to oxygen flow rates for 5 of 5 residents with oxygen in a total sample of 12. (Residents #3, #12, #19, #29, and #37) Findings include: 1. Resident #37's record was reviewed on 2/13/12 at 12:50 p.m. Resident #37's diagnoses included, but were not limited to, hypothyroidism and hypertension. Resident #37's physician order recapitulation, dated 1/12, indicated oxygen continuously at 3 liters per minute. Resident #37 was observed on initial tour on 2/13/12 at 10:05 a.m., through 10:52 a.m., with LPN #39 present with his oxygen on 1.5 liters. LPN #39 indicated	F0328	1. Residents #3, #12, #19, #29 and #37 oxygen were set on the correct liter per physicians orders No negative outcomes were noted. 2. Current residents with orders for oxygen have the potential of being affected by this alleged deficiency . Physician orders for current residents have been reviewed by the DHS /designee and liter flow verified to be on the correct setting.3. The deficiency was evaluated relative to systems , education and compliance. In-servicing for staff will be conducted by the DHS/designee on facility guidelines for following physicians orders and scope of practice of nursing assistants. 4. Nursing leaders /designee will monitor O2 during daily rounds for 4 weeks, biweekly for 4 weeks, weekly for 4 weeks. Audits will include all shifts. Results from audits will be reviewed by the DHS/designee and forwarded to the QA committee with audits expanded if required until 100% compliance	03/23/2012

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	the resident's oxygen should have been on 3 liters and adjusted the flow rate to 3. Resident #37 was observed on 2/14/12 at 9:38 a.m., with his oxygen flow rate on 2.5 liters. Resident #37 was observed on 2/14/12 at 9:47 a.m., with his oxygen at 2.5 liters. LPN #111 indicated the oxygen should have been at 3 liters and adjusted the flow rate to 3. Resident #37 was observed on 2/15/12 at 12:00 p.m., with his oxygen on 2 liters. During an interview on 2/15/12 at 12:15 p.m., RN #124 indicated the resident's oxygen should have been on 3 liters. 2. Resident #19's record was reviewed on 2/14/12 at 2:30 p.m. Resident #19's diagnoses included, but were not limited to, dementia, hypothyroidism, and coronary artery disease. The resident's admission physician's orders, dated 2/10/12, indicated oxygen continuously at 2 liters. Resident #19 was observed on initial tour on 2/13/12 at 10:05 a.m., through 10:52 a.m., with LPN #39 present with her oxygen on 1.5 liters. LPN #39 indicated		is met.	

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	the resident's oxygen was on 1.5 liters and adjusted the flow rate to 2. Resident #19 was observed 2/14/12 at 12:15 p.m., the resident's oxygen flow rate was set on 0. During an interview on 2/14/12 at 12:17 p.m., RN #124 indicated the resident's flow rate on the oxygen concentrator was not working after she attempted to adjust it. She indicated she would have to get a new tank because there was no way to know what the oxygen was set on. 3. Resident #29's record was reviewed on 2/14/12 at 10:50 a.m. The resident's diagnoses included, but were not limited to, seizure disorder, dysphagia (difficulty swallowing), and hypothyroidism. The physician's order recapitulation, dated 1/12, indicated the oxygen continuously at 4 liters per minute. Resident #29 was observed on initial tour on 2/13/12 at 10:05 a.m., through 10:52 a.m., with LPN #39 present with his oxygen flow rate set on 3.5 liters. LPN #39 indicated the resident's oxygen was supposed to be on at 4 liters. Resident #29 was observed on 2/14/12 at 9:31 a.m., with his oxygen on 3.5 liters.			

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	During an interview on 2/14/12 at 9:47 a.m., LPN #111 indicated the resident's oxygen should have been on 4 liters and adjusted the flow rate to 4. 4. During the initial tour on 2/13/12 at 10:05 a.m., Resident #3 was observed sitting up in her wheelchair visiting with her daughter. The resident's oxygen concentrator was set at 2 liters of oxygen. LPN #30 indicated the resident's oxygen level should be set at three liters and turned the oxygen up to 3 liters. Resident #3 was observed up in her wheelchair in the dining room on 2/13/12 at 1:05 p.m. The resident's oxygen level was set at 2 liters. The resident's daughter indicated the CNA had placed the resident's oxygen on when getting her up. LPN #30 indicated the resident's oxygen should have been set at 3 liters. The resident's daughter was observed to turn the resident's oxygen to 3 liters. An interview on 2/13/12 at 1:10 p.m., CNA #91 indicated she had gotten the resident up and into her wheelchair. CNA #91 indicated she had turned the resident's oxygen on. Resident #3 was observed in her room sitting up in her wheelchair on 2/14/12 at 2:00 p.m. The resident's oxygen level			

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	was set at 2.5 liters. An interview on 2/14/12 at 2:03 p.m., RN #116 indicated the resident's oxygen should be set at 2 liters. The resident's daughter indicated the resident's oxygen should be set at 3 liters. RN #116 set the resident's oxygen at 3 liters. Resident #3's record was reviewed on 2/14/12 11:30 a.m. Resident #3's diagnoses included, but were not limited to, congestive heart failure, hypertension and pacemaker. A physician's order, dated 2/2/12 indicated the resident was to receive 3 liters of oxygen continuously. 5. During the initial tour on 2/13/12 beginning at 10:05 a.m., Resident #12 was observed sitting up on the edge of her bed. The resident's oxygen was set at 3.5 liters. LPN #30 indicated the resident's oxygen should be set on 3 liters. Resident #12's record was reviewed on 02/14/12 at 2:20 p.m. The resident's diagnoses included, but were not limited to, hypertension and depression. The physician's recapitulation orders, dated 02/12, indicated an order for oxygen at 3 liters per minute per nasal			

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	cannula. The 02/12 Medication Administration Record, indicated the nurse was to check to ensure the oxygen was flowing at 3 liters. An undated facility policy, provided by the Administrator on 2/15/12 at 9:40 a.m., titled "Guidelines for Administration of Oxygen" indicated "Purpose: To provide guidelines for safe oxygen administration when insufficient oxygen is being carried by the blood to the tissues...." 3.1-47(a)(6)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to monitor residents on hypertension medication and heart medication, for 2 of 12 residents reviewed for monitoring for medications in a total sample of 12. (Residents #20 and #37) Findings include: 1. Resident #37's record was reviewed on 2/13/12 at 12:50 p.m. Resident #37's diagnoses included, but were not limited to, hypertension, hypothyroidism, and	F0329	1. The physician for Resident #37 was notified and orders received for blood pressure parameters. Nursing was instructed to obtain apical pulse of Resident #20 prior to administering Digoxin. 2. Current residents receiving cardiovascular medications that require pulse and /or blood pressure monitoring will be reviewed by the DHS/designee with orders for parameters established if not already determined . DHS/pharmacy consultant will review new orders to ensure hold parameters are	03/23/2012

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	GERD (gastroesophageal reflux disease). Physician's orders, dated 12/24/11, indicated Bystolic (medication for high blood pressure) 5 milligrams give 1 tablet by mouth daily and Cardura (medication for high blood pressure) 2 milligrams give 1 tablet by mouth once daily, and Lasix (diuretic) 20 milligrams every morning. Skilled Nursing Assessment and Data Collection forms indicated blood pressures on the following dates and times: 1/4/12 at 2 a.m., BP 90/53 1/5/12 at 2 a.m., BP 95/50 1/6/12 at 2:15 a.m., BP 80/40 1/8/12 on 11-7 shift, BP 95/61 1/11/12 at 1:45 a.m., BP 90/55 1/12/12 at 12 a.m., BP 95/65 1/25/12 at 2:30 a.m., BP 90/49 2/3/12 at 5:30 a.m., BP 80/50 The January 2012 MAR (Medication Administration Record) indicated Bystolic and Cardura were given after rising every day except on 1/15 due to the resident's BP was 99/67. The February 2012 MAR indicated Bystolic and Cardura were both given on 2/3/12.		addressed. 3. The deficiency was evaluated relative to systems , education and compliance. In-servicing for staff will be conducted by the DHS/designee on facility guidelines for following medication administration. 4. The DHS /pharmacy consultant/designee will monitor medication parameters for 4 weeks, biweekly for 4 weeks, weekly for 4 weeks. Results from audits will be reviewed by the DHS/designee and forwarded to the QA committee with audits expanded if required until 100% compliance is met. Compliance date : 3/23/12	

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	During an interview on 2/14/12 at 10:12 a.m., RN #124 indicated the physician should have been notified of the low blood pressures with the resident on three blood pressure medications. She indicated the nurses should be checking the resident's blood pressure before giving the medications. She indicated they usually have specific orders for blood parameters. She indicated she was going to call the physician today. During an interview on 2/14/12 at 11:54 a.m., the DoN (Director of Nurses) indicated the physician should be called for parameters for the resident's blood pressures. A Professional Resource, titled, "2010 Nursing Spectrum Drug Handbook", page 376, indicated to monitor the patient's blood pressure who is on Cardura. 2. Resident #20's record was reviewed on 2/15/12 at 11 a.m. Resident #20's diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation, and arthritis. The resident's admission physician's orders, dated 1/2/12, indicated Digoxin (heart medication) daily hold if apical heart rate less than 60. The resident's MAR, dated 1/12, indicated			

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	the Digoxin was administered without obtaining an apical pulse on January 21, 22, 23, 26, 27, 28, 29, and 30, 2012. During an interview on 2/15/12 at 12:15 p.m., RN #124 indicated the nurses should have taken an apical pulse and documented on the MAR before administering the Digoxin. The 2010 Nursing Spectrum Drug Handbook, page 350, indicated "...Patient monitoring...Assess apical pulse regularly for 1 full minute, if rate is less than 60 beats/minute, withhold dose and notify prescriber..." 3.1-48(a)(3)			

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F0333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to ensure a resident was free from a significant medication error, related to seizure medication for 1 of 12 residents reviewed for significant medication errors in a total sample of 12. (Resident #29) Findings include: Resident #29's record was reviewed on 2/14/12 at 10:50 a.m. Resident #29's diagnoses included, but were not limited to, seizure disorder, hypothyroidism, and dysphagia (difficulty swallowing). A physician's order, dated 10/26/11, indicated Dilantin (seizure medication) 125 mg (milligrams)/ (per) 5 ml (milliliters) susp (suspension) give 8 ml (200 mg) per peg tube three times a day. A physician's order, dated 10/28/11, indicated Jevity (liquid feeding) 1.5 at 75 cc (cubic centimeters) per hour times 18 hours via peg tube, turn feeding off 1 hour before Dilantin is given and 1 hour after Dilantin.	F0333	1. Resident #29 no longer resides at Spring Mill Health Campus. 2. Current residents receiving tube feedings and anti-seizure medications will be reviewed by the DHS/designee. 3. The deficiency was evaluated relative to systems , education and compliance. In-servicing for staff will be conducted by the DHS/designee on guidelines for following anti-seizure medication administration with enteral feedings. 4. The DHS/pharmacy consultant designee will monitor med administration during daily rounds for 4 weeks, biweekly for 4 weeks, weekly for 4 weeks. Audits will include all shifts. Results from audits will be reviewed by the DHS/designee and forwarded to the QA committee with audits expanded if required until 100% compliance is met.	03/23/2012

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	The February 2012 MAR (Medication Administration Record) indicated the Dilantin was given at 6 a.m., 2 p.m., and 10 p.m. The tube feeding was turned off at 5 a.m. and turned back on at 7 a.m., turned off at 1 p.m. and turned back on at 3 p.m., and turned off at 9 p.m. and turned back on at 11 p.m. every day. A physician's order, dated 2/12/12 at 10:30 a.m., indicated "1. Dilantin 200mg per peg tube 4x's (times) a day x 3 days resume TID (three times a day) on 4th day..." The February 2012 MAR indicated the Dilantin 200 mg was given 4 times a day at 6 a.m., 12 p.m., 6 p.m., and 12 a.m., but lacked documentation the tube feeding was turned off one hour before Dilantin was given and one hour after Dilantin for administration times 12 p.m., 6 p.m., and 12 a.m. During an observation on 02/13/12 at 12:11 p.m., the resident was in bed and the residents tube feeding was infusing at 75 cc (cubic centimeters) per hour. During an observation on 02/14/12 at 11:10 a.m. and 12:15 p.m., the resident was in bed and the tube feeding was infusing at 75 cc/hr.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with LPN #111, on 2/14/12 at 2:45 p.m., she indicated no one changed the times for turning the tube feeding on and off when the orders changed for the Dilantin. A 2010 Nursing Spectrum Drug Handbook, pages 934-936, indicated "...phenytoin (Dilantin)...Interactions...Drug-food. Enteral tube feedings: decreased phenytoin absorption..." 3.1-48(c)(2)			

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	155764	A. BUILDING 00 B. WING	02/22/2012

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F0360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. Based on observation, record review, and interview, the facility failed to provide residents with special dietary needs, a diet as ordered by the physician for 2 of 12 residents reviewed for special dietary needs in a total sample of 12. (Residents #9 and #11) Findings include: 1. During an observation on 02/14/12 at 5:35 p.m., Resident #11 received her supper which included spinach and Italian tomato soup. The resident then informed the CNA she could not have green vegetables and tomato products. The CNA then removed the items from the table. The resident's dietary card indicated the resident was on a regular diet with no bananas, oranges, prunes, melon, tomatoes, or tomato juice and green vegetables. During an interview with the resident at the time of the observation, the resident indicated she is served food she cannot	F0360	1. Resident #11 and #9 were served the correct diet after it was brought to the staff's attention. Both residents were assessed with adverse effects were noted to the residents. 2. All residents diet tray tickets were reviewed any deficiencies noted and were corrected at that time. No adverse reaction were noted to any residents. 3. Dietary will review all records to ensure the accuracy of the tray tickets. Dietary and nursing will be in serviced on following of the tray tickets during meal services, by 3/23/12 by DHS or designee. Director of Dining Services or designee will audit 10 residents per week to ensure accuracy of dietary ticket being followed. Audit will include observation during breakfast, lunch and diner. 4. Director of Dining Service or designee will report findings to the QA Committee monthly for 6 months. If compliance not obtained then QA will expand the audit until 100% compliance is obtained.	03/23/2012

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	have all the time. The resident indicated she just tells them what she cannot have. During an interview on 02/14/12 at 5:40 p.m., Dietary Server employee #24 indicated, "I messed it up." She indicated the resident was not supposed to have the spinach and tomato products. The resident's record was reviewed on 02/14/12 at 6 p.m. The resident's diagnoses included, but were not limited to, coronary artery disease and acute renal failure. The physician's recapitulation orders, dated 02/12, indicated a diet order of a regular diet with no bananas, oranges, prunes, melon, non-boiled potatoes, tomatoes, or tomato juice, sweet potatoes, and yogurt. The resident's Admission/5-day Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact with a score of 15. 2. Resident #9's record was reviewed on 2/15/12 at 11:30 a.m. Resident #9's diagnoses included, but were not limited to, dysphagia (difficulty swallowing), congestive heart failure, and hypertension. A physician's order, dated 2/10/12,			

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	indicated "Change diet to regular c/ (with) nectar thick liquids. Strategies-cut into small pieces, small bites and sips. no straws, upright position during and 30 min (minutes) p/ (after) intake." The resident had been receiving a mechanical soft diet with nectar thick liquids. Resident #9 was observed on 2/14/12 at 5:47 p.m., receiving a mechanical soft diet with nectar thick liquids during the supper meal. The resident's family member indicated she had been telling the facility for four days the resident was supposed to be receiving a regular diet. The resident's dietary card indicated the resident was to receive a mechanical soft diet. During an interview on 2/15/12 at 12:25 p.m., the Nurse Consultant indicated the resident's diet order should have been changed immediately. During an interview on 2/15/12 at 5:58 p.m., the DoN indicated the diet orders should have been change immediately. An interview on 2/15/12 at 11:05 a.m., the Speech Therapist indicated she knew the family member was upset and told the family member if it happens again to come and see her. The Speech Therapist indicated the order for the diet was in the			

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	resident's chart. 3.1-20(a)			

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F0365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review, and interview, the facility failed to provide food in a prepared form to meet the resident's individual needs, related to diet consistency and thickened fluids for 2 of 12 residents reviewed for dietary needs in a total sample of 12. (Residents #8 and #13) Findings include: 1. Resident #8 was observed on 2/14/12 at 11:50 a.m., sitting up in his wheelchair by the nurses' station. CNA #57 was observed to give the resident an orange at his request and then placed the resident at the dining room table. CNA #90 was observed at 11:55 a.m., to walk over to the resident and peel the orange for him and leave the resident by himself to eat the orange. Resident #8's record was reviewed on 2/14/12 at 9:44 a.m. Resident #8's diagnoses included, but were not limited to, intercerebral hemorrhage, muscle weakness, and dysphagia. An admission MDS (Minimum Data Set)	F0365	1. Resident #8 was assessed and no adverse side effects were noted from eating the orange. Resident # 13 was assessed for eating the salad and no adverse effects were noted to the resident. 2. All residents during meal services were reviewed to ensure they received the correct diet, any deficiencies noted were corrected at that time. 3. Dietary will review all records to ensure the accuracy of the tray tickets. Nursing will be in serviced on following of the tray tickets for meal service by the DHS or designee by 3/23. The DHS or designee will monitor 10 residents per week to ensure accuracy of diet being served. DHS or designee will oberve breakfast, lunch and diner mealtimes. DHS or designee will report findings to QA monthly. 4. DHS or designee will report findings to the QA Committee monthly for 6 months. If compliance is not obtained then QA will expand the audit until 100% compliance is obtained. 5. Compliance date: 3/23/12	03/23/2012

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	assessment, dated 1/3/12, indicated the resident was severely impaired for cognition and required extensive one person assistance for eating. A care plan for impaired cognitive skills, dated 12/27/11, indicated the resident had memory and recall problems. A care plan for nutrition risk, dated 1/27/12, indicated "...provide mechanically altered diet..." There was a lack of documentation in the care plan for the resident's thickened liquids. A February 2012, physician's order indicated the resident was to receive nectar thick liquids. A 2/8/12, speech therapy note, indicated the resident had impaired cognitive linguistic skills and oropharyngeal dysphagia. The 2/8/12, speech therapy note indicated the resident was consistent with a mechanical soft diet and nectar thick liquids. An interview with the DoN on 2/14/12 at 12:05 p.m., indicated the resident should not have been given the orange. An interview on 2/15/12 at 11:05 a.m., the Speech Therapist indicated the CNAs need to know what consistency the			

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	resident was on. The Speech Therapist indicated the resident "could have choked." The Speech Therapist indicated juice from the orange was not nectar thick and the orange was not mechanical soft. 2. Resident #13 was observed on 2/13/12 at 12:47 p.m., up in her wheelchair at the dining room table eating a regular salad. The resident was observed to place a piece of the lettuce in her mouth, tear the lettuce into small pieces and place most of the pieces back in her salad bowl. Resident #13 continued to eat the lettuce this way without any intervention from staff. At 12:55 p.m., Resident #13 was observed to be served pureed spaghetti and meatballs and garlic bread. LPN #30 indicated the resident should not have received the regular salad. Resident #13's record was reviewed on 2/15/12 at 10:45 a.m. Resident #13's diagnoses included, but were not limited to, dysphagia (difficulty swallowing), and dementia. An admission MDS assessment, dated 2/2/12, indicated the resident cognition was moderately impaired and the resident required setup and supervision of one staff for eating.			

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	The resident menu card for 2/14/12 indicated the resident was to receive a regular pureed diet with honey thick liquids. A physician's order, dated 1/27/12, indicated a pureed diet with honey thick liquids. A care plan for aspiration/choking, dated 2/02/12, indicated "puree diet as ordered." An interview on 2/15/12 at 11:05 a.m., the Speech Therapist indicated she had examined the resident after being given the salad to make sure there was no residual. The Speech Therapist indicated the "puree" should be put in front of the regular on the diet card. An interview on 2/14/12 at 12:25 p.m., the Dining Service Support Person indicated the server should have been reviewing the dietary cards. 3.1-21(a)(3)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to distribute and serve food under sanitary conditions related to, open and undated food, dirty ovens, chipped bowl, dirty garbage can, dirty cart/cabinet, containers, dirty microwaves, ice machines, juice and coffee machines, ice carts, refrigerators, freezers, unlabeled and undated food, food on the floor, and storing glassware on the floor for 1 of 1 Kitchen, 3 of 3 Dining Rooms (Rehab, Healthcare 1 and Healthcare 2), 1 of Serving Kitchen (Healthcare 1), and 1 of 2 lounges (Main Lounge). This had the potential to affect 44 of 48 residents who consumed food prepared in the kitchen out of a total population of 48. Findings include: 1. Kitchen During the initial tour on 2/13/12 beginning at 10:05 a.m., with the Dietary Manager and the Dietary Manager Assistant, the following was observed in	F0371	1. The facility microwaves, juice machines, coffee machines, coolers, ice machines, oven, garbage cans, utility carts, ice carts, cabinets, refrigerators, and silverware containers were cleaned /sanitized. All dishes were checked and discarded/replaced if chipped. The dishwasher heater boaster was replaced. Stored food was checked to assure it was dated related to date opened, date prepared, and use-by-date. 2. All residents have the potential to be affected by this deficiency. Upon review no resident was noted to be affected by this deficiency. 3. The deficiency was evaluated related to system, education and compliance. In-servicing of staff will be conducted by the Food Servicing Manager /designee by March 23, 2012 related to required cleaning schedules/procedures, and dating/storage of opened food. 4. The Food Service Manager/designee will audit completion of required cleaning schedule, storage/ dating of food, dishwasher temperatures, ice machine maintenance, dish	03/23/2012

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	the kitchen: A. The front and sides of both convection ovens were dirty with dried liquid. During an interview at the time of the observation, the Dietary Manager indicated they are supposed to be wiped down every evening, "doesn't look like it was done last night." B. The cart/cabinet that holds the scoops was dirty with debris. During an interview at the time of the observation, the Dietary Manager indicated it gets cleaned out once a week. C. One of twelve stored and ready to use small bowls was chipped. During an interview at the time of the observation, the Dietary Manager indicated he would throw it out. D. The container that stored clean and ready to use butter knives was dirty with dried food debris. E. In the freezer there was a opened bag of sausage links, a opened bag of peas, and a opened bag of steak burgers without open dates or use by dates. F. The garbage can by the dry storage room was dirty.		storage/condition daily. Audit results will be forwarded to the monthly QA Committee for 6 months.	

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	G. There was a red rack, with stored and ready to use small glasses and carafes, setting on top of another rack on the floor. During an interview at the time of the observation, the Dietary Manager indicated "they should not be there." H. The temperature of the dishwasher's wash cycle was 140 degrees and the rinse cycle was 120 degrees. During an interview at the time of the observation, the Dietary Manager Assistant indicated the wash cycle should be at 150 degrees. The Dietary Manager indicated the dishwasher had been fixed last week and the temperature was fine this morning. The Dietary Manager Assistant indicated they would use paper products until the dishwasher gets fixed. A facility policy titled "Date Marking," dated 2009 and received as current on 2/14/12 at 11 a.m., indicated "...8. Items will be marked with both the date prepared and the use-by date..." An undated, facility policy, received as current from the Director of Nursing on 02/22/12 at 8:35 a.m., titled, "Washing Dishes", indicated, "...Set all controls for operation of machine. (Wash 160 o (degrees), Rinse 180 o)..." A facility policy, dated 2009, received			

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	from the Executive Director current, titled, "Cleaning Dishes and Utensils-Dish Machine Operation", indicated, "...wash temp should be 145-160 o; rinse tem (sic) should be 180-194 o..." 2. During an observation on 02/14/12 at 5:10 p.m., the inside of the microwave in the second floor dining area had red splatters and dried food splatters. During an interview at the time of the observation, LPN #111 indicated the microwave did not look like it had been cleaned for a while. She indicated housekeeping was supposed to clean the microwaves. 3. During the environmental tour on 02/15/12 at 10:30 a.m. through 11:15 a.m. with the Executive Director (ED), the Housekeeping Supervisor, and the Maintenance Supervisor, the following was observed: A. There were food splatters inside the microwave located in the Main Lounge. During an interview at the time of the observation, the ED indicated the lounge was used by the residents in the whole building. The ED acknowledged the dirty microwave. B. The Rehabilitation Dining Room had			

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	food splatters on the inside of the microwave, there was undated resident food in the refrigerator, and four undated styrofoam cups of ice cream with frost build up on the ice cream. The styrofoam cups were loosely covered with plastic wrap. During an interview at the time of the observation, the ED indicated the dietary department were suppose to monitor the refrigerator and freezer. C. In the Second Floor Dining Room, there was a build up of juice splatters on and around the juice nozzles of the juice machine, a build up of dry coffee on the coffee machine, the cooler for ice and the ice cart had dark brown liquid spills. The Maintenance Supervisor indicated he was unsure what the dark brown liquid was. D. In the First Floor Dining Room, there was a build up of juice splatters on and around the juice nozzles of the juice machine and a build up of dried coffee on the coffee machine. E. In the first floor Serving Kitchen: There were 14 uncovered/undated styrofoam cups on a tray in the freezer. The plastic wrap had been pulled away from the ice cream and written on the wrap was, "HI." The refrigerator had a bag of cinnamon			

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	swirl bread that was left opened to air. The ice cooler was full of ice and water, the outside of the cooler had a liquid brown substance spilled on the lid and the bottom shelf of the cart had an accumulation of dirt on it. The ice machine was full of ice and there was a light colored oily substance on the plastic piece inside the machine touching the ice. During an interview at the time of the observation, the Maintenance Supervisor indicated it was water sediment. He indicated the company comes out to clean the ice machine every six months. He indicated he was unsure when the last time the ice machine had been cleaned. An undated facility policy, received as current from the Director of Nursing on 02/16/12 at 8:35 a.m., titled, "Cleaning instructions: Ice Machine and Scoop", indicated, "Policy: The ice machine and scoop will be cleaned and sanitized on a routine basis according to defined procedures...4. Scrub all machine surfaces and door gaskets inside and out with hot detergent solution...6. Sanitize inside with clean cloth saturated with sanitizing solution..." The manufacturer's instructions for the ice			

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	machine, dated 07/06, received from the Director of Nursing as current, indicated, "...It is the User's responsibility to keep the ice machine and ice storage bin in a sanitary condition. Without human intervention sanitation will not be maintained...." An undated facility policy, received as current from the Executive Director on 02/16/12 at 8:25 a.m., titled, "Cleaning Schedules", indicated, "Policy: The nutrition Services Department will be cleaned and sanitized on a routine basis according to written cleaning schedules...B. Daily:...Juice Machine...Carts...Coffee Machine...C. Weekly:...Ice Machine..." 3.1-21(i)(2) 3.1-21(i)(3) 5-1.5(k) 5-1.5.1(f)			

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	155764	A. BUILDING 00 B. WING	02/22/2012

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F0372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation and interviews, the facility failed to dispose of garbage and refuse properly, related to an open, overflowing garbage dumpster, trash bags on the ground around the garbage dumpster, and loose garbage on the ground around the garbage dumpsters for 2 of 3 outside garbage dumpsters on 1 of 1 day of observations. Findings include: During the environmental tour on 02/15/12 (Wednesday) at 10:30 a.m. through 11:15 a.m. with the Executive Director (ED), the Housekeeping Supervisor, and the Maintenance Supervisor, there were three garbage dumpsters outside behind the building. The center garbage dumpster had both lids open and there were trash bags over flowing out the top of the dumpster. The second dumpster was half full and there was a garbage bag lying on the ground behind the second dumpster. There was loose garbage and food containers on the ground around the two	F0372	1. The trash was picked up and placed in the dumpster during the survey. No adverse reaction was noted. 2. The facility reviewed the other dumpster to ensure all trash was picked up and placed in the dumpster. Any deficiencies noted at that time were corrected. 3. Staff will be in-serviced on placing the trash in the dumpster and ensuring the lids are closed for proper disposal by the Executive Director or designee by 3/23/12. 4. The Plant Operations Director will audit trash pick up five times per week to ensure compliance of guidelines. The Plant Operations Director will present results monthly to the QA Committee for 6 months.	03/23/2012

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	dumpsters. During an interview at the time of the observation Maintenance Supervisor indicated the garbage was scheduled to be picked up on Friday. 3.1-21(i)(5) 5-1.5(l)			

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure medication orders were clarified, medications were provided, and administered as ordered by the resident's physician, for 2 of 12 residents in a sample of 12. (Residents #12 and #38) Findings include: 1. Resident #38's record was reviewed on 2/15/12 at 11:37 a.m. Resident #38's diagnoses included, but were not limited to, Parkinson's disease, arthritis, and hypothyroidism. Resident #38 was	F0425	1. The physician was contacted to clarify the order for the Synthroid for Resident #38. Resident is to be given 75mcg. Resident # 12 Physician was notified at the time of the survey . Lab values were within normal limits. Physician did not want to continue potassium. No negative outcomes. 2. Orders will be reviewed to verify that no other orders need clarification and orders have been transcribed to the MAR. 3. Staff will be in-serviced by the DHS or designee by 3/23/12 on order clarification and accuracy of MAR. 4. New orders will be reviewed in daily stand up	03/23/2012

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	admitted to the facility on 1/20/12. Admission orders, dated 1/20/12, indicated "...levothyroxine (Synthroid) (thyroid medication) 75 mcg (micrograms) take 100 mcg p.o. (orally) daily 6A (a.m.)..." A MAR (Medication Administration Record), dated January 2012, indicated levothyroxine (Synthroid) 75 mcg (micrograms) take 100 mcg p.o. daily 6 a.m. and was initialed as given 1/21-1/30. A MAR, dated February 2012, indicated levothyroxine 100 mcg give 1 tablet daily after rising and was initialed as given 2/1-2/15. The record lacked documentation of an order to clarify what dose of levothyroxine was to be given 75 mcg or 100 mcg. There was a lack of documentation to indicate the pharmacy had asked the facility for clarification of the order. During an interview with RN #124, on 2/15/12 at 2:20 p.m., she indicated she would call the physician and clarify the Synthroid. A physician's order, dated 2/16/12 at 9		meeting to ensure clarity of orders and transcriptions to MARs. Results will be reviewed by the DHS and presented monthly to the QA committee for a period of 6 months.	

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	a.m., indicated give Synthroid 75 mcg everyday. The order lacked clarification of the time to be given. During an interview with LPN #30, on 2/16/12 at 11 a.m., she indicated they were giving levothyroxine 100 mcg and called the physician to clarify the order and he ordered levothyroxine 75 mcg. 2. Resident #12's record was reviewed on 02/14/12 at 2:20 p.m. The resident's diagnoses included, but were not limited to, hypertension and depression. A chemistry profile (laboratory test for electrolytes), dated 01/31/12, indicated the resident's potassium level was low at 3.2 (normal 3.5-5.3). A physician's order, dated 01/31/12 at 3:45 p.m., indicated an order for potassium 20 meq (milliequivalents) daily. There was a lack of documentation on the resident's Medication Administration Record, dated 02/12, to indicate the resident had an order and had been receiving the potassium 20 meq daily from 02/01/12 to 02/03/12 (resident was transferred to the hospital on 02/03/12). During an interview on 02/14/12 at 3:30			

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	p.m., the Director of Nursing indicated the potassium 20 meq had not been given as ordered by the physician. 3.1-25(b)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure	F0441	1. Resident #19 and #38 have been given Mantoux testing per	03/23/2012

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	infection control protocols were followed related to tuberculin testing for 2 of 12 residents reviewed for tuberculin testing (Residents #19 and #38), the facility failed to ensure nursing staff followed handwashing and glove use procedures for 1 of 11 residents observed for resident care (Resident #65) in a total sample of 12, and failed to ensure linens were handled in a way to prevent contamination during 5 of 5 observations on 2 of 3 units which had the potential to affect 38 residents housed on the two units. (Healthcare 1 and Healthcare 2) Findings include: 1. Resident #19's record was reviewed on 02/14/12 at 2:30 p.m. The resident's diagnoses included, but were not limited to, dementia and congestive heart failure. The resident was admitted into the facility on 02/10/12. The transfer forms from the hospital, dated 02/09/12 and 02/10/12, lacked documentation a Mantoux (tuberculin test) had been completed prior to transferring the resident to the facility. The resident's admission orders, dated 02/10/12, indicated an order to give the first step Mantoux on 02/10/12 and to read the test on 02/12/12.		requirements. Resident #29 was not affected by the deficient infection control practice of the CNA. 2. Resident records will be reviewed to verify Mantoux testing has been completed per requirements. 3. Staff will be in-serviced by the DHS/designee by 3/23/12 regarding proper handling of linen, hand washing and completion of Mantoux testing. 4. New admission records will be reviewed in daily stand up meetings to verify Mantoux testing is completed. DHS or designee will spot check to ensure proper hand washing technique and linen handling are being followed. The DHS or designee will include all shifts in the random audits. DHS or designee will monitor 3 staff members per week including all shifts in the random audits. DHS or designee will report findings to the monthly QA Committee for 6 months, and, if necessary, the QA Committee will expand the audit until 100% compliance is obtained.	

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The resident's Medication Administration Record, date 02/12, lacked documentation to indicate the Mantoux had been given and read by the facility.

During an interview on 02/14/12 at 2:45 p.m., employee LPN #11 indicated she did not know why the Mantoux was not given on 02/10/12 when it was ordered to be given.

2. CNA #94 was observed holding linens up against her uniform on 2/14/12 at 1:10 p.m., on the second floor walking by the nurses' station.

An undated facility policy titled "Guidelines for Handling Linen", provided by the administrator as current on 2/15/12 at 9:40 a.m., indicated "...Linens should be carried away from the body to prevent contamination from clothing..."

3. CNA #50 and CNA #65 were observed transferring Resident #29 from the bed to his chair with the Hoyer lift on 2/15/12 at 10:40 a.m. CNA #65 was observed handing the resident's catheter tubing/bag under the resident's wheelchair to CNA #50. She then adjusted the resident's clothing. CNA #65 then took the Hoyer lift out of the resident's room without removing her gloves or washing her

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	hands. CNA #65 then came back into the room and removed the soiled linens from the bed and placed in a bag. She then removed her gloves and applied a clean pair of gloves. CNA #65 then placed the call light in the resident's hand, gathered the soiled linen removed her gloves and left the resident's room without washing her hands. A facility policy, dated 10/2004, titled "HANDWASHING" received on 2/17/12 at 11 a.m., from the Corporate Nurse Consultant as current indicated "...Health Care Workers shall wash hands...Before/After having direct contact with residents...After removing gloves..." . 4. Resident #38's record was reviewed on 2/15/12 at 11:37 a.m. Resident #38's diagnoses included, but were not limited to, Parkinson's disease, arthritis, and hypothyroidism. Resident #38 was admitted to the facility on 1/20/12. A physician's order, dated 2/12/12 at 12 p.m., indicated "1. 1st step PPD (tuberculin skin test, Mantoux) 2/13/12, Read 2/16/12 2. 2nd step PPD 2/27/12, Read 3/1/12." A MAR (Medication Administration Record), dated February 2012, lacked documentation the 1st or 2nd step PPD's			

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	were given. An Immunization Record lacked documentation the 1st or 2nd step PPD's were given. The record lacked documentation of any previous PPD's given prior to admission. During an interview with RN #124, on 2/15/12 at 12 p.m., she indicated the PPD's were not given. She indicated they should have been given on admission. An undated facility policy titled "TB Screening: Residents," received as current by the DoN (Director of Nursing), on 2/16/12 at 8:25 a.m., indicated "Policy: All resident [sic] either prior to or upon admission, in accordance with state and federal regulations will receive a 2-step Mantoux test for tuberculosis..." 5. CNA #91 was observed in the HC 1 (Healthcare 1) dining room on 2/13/12 at 12:20 p.m., passing out clothing protectors to the residents. CNA #91 was observed to be holding the clothing protectors up against her uniform. 6. Dietary Staff #102 was observed in the HCC 1 dining room on 2/14/12 at 11:15 a.m., folding linen napkins. Dietary Staff #102 was observed to hold the clean linen napkins up against her apron.			

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	7. CNA #82 was observed on 2/14/12 at 5:00 p.m., in the HCC 1 dining room passing out clothing protectors to the residents. CNA #82 was observed to hold the clothing protectors up against her uniform. CNA #82 indicated she was not supposed to hold the linen clothing protectors against her uniform. 8. CNA #35 was observed on 2/14/12 at 5:35 p.m. in the HCC 1 dining room passing out clothing protector to the residents. CNA #35 was observed to hold the clothing protectors against his uniform. CNA #35 indicated at 5:37 p.m., the linens should be held away from the uniforms. 3.1-18(f) 3.1-18(j) 3.1-18(l) 3.1-19(g)			

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F0465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the kitchen floors were clean or free from debris,related to dirty floors for 1 of 1 kitchen and 1 of 1 Serving Kitchen. (Kitchen and Serving Kitchen) during 1 of 1 observation of each kitchen. Findings include: 1. Kitchen During the initial tour on 2/13/12 beginning at 10:05 a.m., with the Dietary Manager and the Dietary Manager Assistant, the following was observed in the kitchen: A. The floor where the old steamer was removed, there was a black substance all over the floor. During an interview at the time of the observation, the Dietary Manager indicated they were getting a new steamer and they would get it cleaned. B. The floor by the dishwasher was dirty with a black substance.	F0465	1. The floor in the dietary department was cleaned during survey. The potato was removed from behind the refrigerator door during survey. No adverse reaction was noted to any resident. 2. All floors in all the dietary department were assessed any deficiencies noted were corrected at that time. 3. Dietary will be in serviced by Director of Dining Service by 3/23 on the proper technique for cleaning of the floors. The floors will be placed on a schedule for cleaning by the Director of Dining Service or designee. The Director of dining Services or designee will audit the floors cleaning to ensure compliance by performing weekly rounds. Director of dining services will report findings to QA monthly. 4. Director of dining services will report to QA monthly. QA will monitor for any trends and make recommendations to the plan of correction as needed for three months.	03/23/2012

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	C. During the environmental tour on 02/15/12 at 10:30 a.m. through 11:15 a.m. with the Executive Director (ED), the Housekeeping Supervisor, and the Maintenance Supervisor, the following was observed: In the first floor Serving Kitchen there was a whole potato found on the floor behind the refrigerator. 3.1-19(f)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure medical records were complete related to daily Skilled Nursing assessment and Data Collection forms (daily Nurses' charting) for 1 resident in a sample of 12 residents reviewed for complete medical records. (Resident #13) Findings include: Resident #13's record was reviewed on 2/15/12 at 10:45 a.m. Resident #13's diagnoses included, but were not limited to, dysphagia (difficulty swallowing, and dementia. The resident's record lacked documentation of the daily Skilled Nursing assessment and Data Collection forms after 1/30/12.	F0514	1. Resident was assessed and 72 hour charting initiated. Physician was called and an updated status report was given. 2. All residents have the potential to be affected by this deficiency. Resident records were reviewed with no negative outcomes noted related to this deficiency3. The deficiency was evaluated related to system, education and compliance. In-servicing for licensed nursing staff will be conducted by the DHS /designee by March 23, 2012 related to required nursing assessment and completion of documentation. 4. The MDS Coordinator/designee will audit required charting completion 5 days per week for 6 months. Results from audits will be reviewed by the DHS/designee and presented monthly to the QA Committee for 6 months.	03/23/2012

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	155764	A. BUILDING 00 B. WING	02/22/2012

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	An interview on 2/15/12 at 11:30 a.m., the ADoN (Assistant Director of Nursing) indicated she could not find the daily Skilled Nursing assessment and Data Collection forms from 01/31/12 through 02/14/12. 3.1-50(a)(1)			

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F9999	3.1-14 PERSONNEL In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure facility staff received six hours of training (Employees #48 and #95) and three hours of dementia specific training (Employees #24, #45, #46, #50, #65, #69, #71, #79, #83, #85, #90, #98, #108, #112, #121, #123, and #127) annually for 19 of 98 employees who had been employed at the facility for more than six months. Findings include:	F9999	1. All employee files were reviewed, and employees who did not meet the requirement related to required dementia training were scheduled for in-servicing.2, Facility will ensure employees upon hire are scheduled for dementia training. Annual in-servicing will be provided for all current employees in a timely manner.3. Facility will maintain a tracking log to ensure that all employees continue to receive additional dementia training as required.4. The Business Office Manager or her designee will monitor the dementia training log to ensure that all employees have received scheduled dementia training as required. This check will be done a minimum of once monthly for 6 months. Audit results will be presented monthly to the QA Committee until 100% compliance is achieved.	03/23/2012

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	Dementia specific training records were reviewed on 02/16/12 at 1 p.m. There was a lack of documentation to indicate 19 of 98 employees had received the initial six hours of dementia training (Employees #48 and #95) or the three hours of dementia training required yearly (Employees #24, #45, #46, #50, #65, #69, #71, #79, #83, #85, #90, #98, #108, #112, #121, #123, and #127). During an interview on 02/16/12 at 12:11 p.m., Human Resources indicated the nursing department sets up the training. During the daily conference with the Executive Director, Director of Nursing, and the RN Corporate Consultant, they acknowledged the training had not been completed and no further information was received. 3.1-14(u)			

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R0000	The following State Residential findings are cited in accordance with 410 IAC 16.2-5.	R0000	The submission of this plan of correction does not indicate an admission by Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus . This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities.(for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

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R0036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to notify a resident's physician and family related to a resident not receiving medication as ordered by the resident's physician for 1 of 7 residents reviewed for physician and family notification in a sample of 7. (Resident #114) Findings include: Resident #114's record was reviewed on 02/14/12 at 10:05 a.m. The resident's diagnosis included, but was not limited to, vascular dementia. The resident was admitted into the facility on 02/06/12. The resident's physician's orders, dated 02/06/12, indicated an order for the following supplements: Vitamin B6 25 mg (milligrams), Folate 800 mcg (micrograms), Vitamin B12 400 mg twice a day.	R0036	1. Resident #114 had their physicians notified at the time of survey. They have been evaluated with no negative outcomes noted. 2. Current residents MAR'S for the past 30 days were reviewed any deficiencies noted were corrected at that time. No negative outcomes were noted to any resident. 3. The licensed staff will be in-serviced on the facility guidelines of ordering medications, family notification of ordering medication and physician notification if medication not available. 4. The MAR's will be reviewed by the DHS or designee at least five days per week for any findings requiring notification. DHS or designee will present findings monthly to the QA Committee for 6 months and, if necessary, the QA Committee will expand the audit until 100% compliance is obtained.	03/23/2012

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	The resident's Medication Administration Record (MAR), date 02/11, indicated the supplements were to be provided by the family. The MAR indicated by initials with circle around them, the supplements were not given twice a day as ordered from 02/07/11 through 02/14/11. There was a lack of documentation in the resident's record to indicate the resident's physician had been notified the resident had not received the supplements. There was a lack of documentation in the resident's record to indicate the family had been notified about the physician's order for the supplements and the need for the family to bring the medications in to the facility. During an interview on 02/14/12 at 10:20 a.m., LPN employee #37 indicated she had called the family on 02/14/12, but they did not answer the phone. She indicated no one had notified the family. During an interview on 02/14/12 at 10:20 a.m., the Director of Nursing indicated there was no documentation of the physician being notified of the resident not receiving the medications.			

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R0117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was at least one staff member with a current first aid and CPR (cardiopulmonary resuscitation) certificate scheduled for the day and night shift for 5 shifts in 7 days of schedules reviewed. Findings include: Review of the nursing staff schedules,	R0117	1. Schedule was reviewed during survey and adjustments were made to ensure guidelines were met. 2. All resident had the potential to be effective by this. No adverse effects were noted to the residents. 3. Staff will be scheduled for training. The DHS or designee will develop list of staff that have CPR & First Aid training and will ensure the schedule reflects one a wake person trained in both on each shift. Facility will set up training	03/23/2012

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	dated 02/06/12 through 02/13/12, received as current by the Director of Nursing (DoN), indicated there were no employees scheduled for duty who had both a CPR and a first aid certificate for 02/06/12 day shift, 02/08/12 night shift, 02/10/12 day shift, 02/11/12 day shift, and 02/11/12 night shift. During an interview on 02/16/12 at 12:15 p.m., the Human Resource Director indicated if the staff have CPR and First Aid she makes a copy and places it in the binder. She indicated she did not know who is responsible now for the training of the staff for CPR and First Aid. During an interview on 02/16/12 at 1 p.m., the Director of Nursing provided no further information about the CPR and First Aid certifications.		for other staff. 4. DHS or designee will monitor staffing daily to ensure facility guideline is met. DHS or designee will present findings to the QA Committee monthly for 6 months and, if necessary, the QA Committee will expand the audit until 100% compliance is obtained.	

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R0154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, and interview, the facility failed to keep kitchens, kitchen areas, dining areas, and equipment clean related to dirty cabinets, dirty freezers, and failed to ensure food was dated for 1 of 2 kitchens (Legacy Unit), 1 of 2 Dining Rooms (Main Dining Room), and 1 of 3 lounges (Pub Lounge). Findings include: 1. During the environmental tour on 02/15/12 at 11:15 a.m. through 12:15 p.m., with the Executive Director (ED), the Housekeeping Supervisor, Dietary Manager, and the Maintenance Supervisor, the following was observed: A) Legacy Kitchen: There was an undated pan of cut up zucchini in the refrigerator. The Dietary Manager indicated the zucchini was for tonight's supper. B) Freezer: There were eight uncovered, undated	R0154	1. All undated food was removed from the freezer during the survey. All outdated food was removed from the freezer during the survey. The freezer was cleaned during the survey. The outside of the ice machine was cleaned during the survey. Dining room ice cream, freezer, juice machine nozzles, drawers under counter, table cloths, and the spills on the cabinets were cleaned. The cabinets were cleaned inside and outside of any spills. 2. All residents have potential to be effected by the alleged deficient practice. All areas of the freezer, refrigerators and general kitchen areas in Legacy were inspected for cleaning, any area found to be deficient were cleaned at that time. No adverse reactions were noted to any residents. 3. The environmental service staff and dietary staff will be in-serviced on cleaning procedures related to freezers, refrigerators and cabinets. The dietary staff will be in-serviced on dating of items and the facility guidelines on removing outdate food in the freezers and refrigerators. 4.Environmental Service Director or designee will monitor five times per week to	03/23/2012

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	bowls of ice cream . There was an undated, open bag of frozen pancakes A container identified by the Dietary Manager as beef stroganoff, with loose plastic covering, dated 12/11, that had frost build up on the food. There were spills and crumbs in the bottom of the freezer. There were three bags of an undated, unlabeled light brown substance with frost on the inside of the bags. The Dietary Manager indicated the bags were filled with mashed up bananas for banana bread. He indicated he was unsure when the bags were put in the freezer. There were liquid spills and dried juice on the outside of the ice machine. C) Main Dining Room: There was spilled, dried ice cream on the inside of the ice cream freezer. There was an accumulation of juice on the juice machine on and around the nozzles. Four of four drawers under the counter had spilled brown liquid in and on the		ensure cleaning guidelines are being met. The Director of Dining Services or designee will monitor daily five times per week to ensure the cleaning and storage of food are meeting the guidelines. The Environmental Service Director or designee and the Director of Dining Services or designee will report findings to the QA Committee monthly for 6 months and, if necessary, the QA Committee will expand the audit until 100% compliance is obtained.	

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	drawers. There was a table cloth with a dark brown, dried liquid substance on the cloth stored in the cabinet. There were brown spills and juice spills on the inside of three of three cabinets. The Dietary Manager indicated at the time of the observation, the ice cream freezer, drawers and cabinets should have been cleaned daily. D) Pub lounge: The cabinet where the popcorn and oil were stored had a spilled yellow substance on the shelf. The ice cream freezer had a build up of ice and crumbs in the bottom of the freezer.			

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R0214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure pre-admission and semi-annual evaluations were completed for 2 of 7 residents reviewed for evaluations in a sample of 7. (Residents #62 and #85) Findings include: 1. Resident #85's record was reviewed on 02/14/12 at 11:45 a.m. The resident's diagnoses included, but were not limited to chronic pain and laryngeal cancer. The resident's last admission date into the facility was 10/24/10. The resident's last semi-annual evaluation was dated 01/24/12. There was a lack of documentation to indicate an evaluation had been completed on the resident semi-annually between the dates of 10/24/10 and 01/24/12. During an interview on 02/15/12 at 1:40 p.m., the Assistant Director of Nursing	R0214	1. Residents #85 residents semi- annual assessment was completed 1/24/12- with no preceding assessment, no adverse reaction was noted from not having preceding assessment. Resident #62 pre-admission assessments were not completed. No adverse reaction was noted to the residents. 2. All resident have the potential to be effective. Records were reviewed any that had deficiencies noted were corrected at that time. No negative outcome was noted to any residents. 3. DHS or designee will complete the pre-admission and semi- annual assessment per the facility guidelines. 4. All new admissions will be audited by the DHS or designee to ensure the pre-admission assessments are being completed per the facility guidelines. The residents charts will be audited by the DHS or designee for current semi-annual assessments, any resident not currentl will be completed by the DHS or designee. The DHS or designee will monitor five days per week for 6 months to ensure	03/23/2012

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	indicated she could not locate a semi-annual evaluation. 2. Resident #62's record was reviewed on 02/16/12 at 9:30 a.m. The resident's diagnoses included but were not limited to, anemia and hypertension. The resident had a readmission date of 11/17/11. There was a lack of documentation to indicate a pre-admission evaluation had been completed prior to the resident's readmission on 11/17/11. During an interview on 02/16/12 at 12:35 p.m., the Corporate RN Nursing Consultant indicated a pre-admission evaluation had not been completed.		the assessments are completed. The DHS or designee will report findings to the QA Committee monthly for 6 months and, if necessary, the QA Committee will expand the audit until 100% compliance is obtained.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to identify and document and update services provided by the facility, related to service plans for 3 of 7 residents reviewed for service plans in a sample of 7. (Residents #62, #85, and #95)	R0217	1. Resident #62, #85, #95 service plans were updated during the survey. 2. All resident have potential to be effected by alleged deficient practice. Residents records were reviewed any deficiencies noted were corrected at that time. No negative outcome was noted to any resident. 3. Services plans will be reviewed	03/23/2012

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	155764	A. BUILDING 00 B. WING	02/22/2012

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	Findings include: 1. Resident #62's record was reviewed on 02/16/12 at 9:30 a.m. The resident's diagnoses included but were not limited to, anemia and hypertension. The resident had a readmission date of 11/17/11. There was a lack of documentation to indicate the resident had a service plan completed. During an interview on 02/16/12 at 12:35 p.m., the RN Corporate Nursing Consultant indicated there was no service plan for the resident. 2. Resident #85's record was reviewed on 02/14/12 at 11:45 a.m. The resident's diagnoses included, but were not limited to chronic pain and laryngeal cancer. The resident's last admission date into the facility was 10/24/10. The physician's recapitulation orders, dated 02/12, indicated an order, dated 12/30/11, to administer one sterile saline pack to tracheostomy and deep suction two times a day. The resident's service plan, dated		with either the resident or resident's family member. 4. DHS or designee will audit the service plans and update any service plans according to the facility guidelines. DHS or designee will monitor all new admission and monthly service plans due, to ensure facility guidelines are being followed for scheduled completion of Service Plans. DHS or designee will audit monthly for 6 months. DHS or designee will report findings to the QA Committee monthly for 6 months and, if necessary, the QA Committee will expand the audit until 100% compliance is obtained.	

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	01/24/12, lacked documentation to indicate the staff were completing the tracheostomy care on the resident two times daily. During an interview on 12/15/12 at 12:20 p.m., the Assistant Director of Nursing (ADoN) indicated the resident had an order for deep suctioning, but she was not sure if the staff were doing the deep suctioning. 3. Resident #95's record was reviewed on 02/15/12 at 2 p.m. The resident's diagnoses included but were not limited to diabetes mellitus and macular degeneration. A physician's order, dated 10/25/11, indicated to discontinue the chair alarm. The resident's service plan, dated 11/29/11, indicated the resident had a chair alarm. During an interview on 02/15/11 at 2:20 p.m., the ADoN indicated the resident's service plan had not been updated. She indicated the service plan still indicated the resident has a chair alarm.			

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R0241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review, and interview, the facility failed to administer medications as ordered by residents' physicians, related to not administering the correct dose of medications, omitting doses of medications, and not performing blood sugar monitoring as ordered for 2 of 5 residents (Residents #86 and #88) observed during 1 of 2 medication administration passes observed, and 2 of 7 residents (Residents #95 and #114) reviewed for medications and glucose monitoring in a total sample of 7. Findings include: 1. During a medication administration observation on 02/15/12 at 8:10 a.m., LPN employee #30 prepared Resident #86's morning medications, which included potassium 10 meq (milliequivilents) two tabs daily. LPN #30 removed one capsule of the potassium out of the card and placed it in the plastic medication cup. LPN #30 then entered the resident's room after the	R0241	1. Resident #86, #88, #114, and #95 were evaluated at the time of survey and no negative outcomes were noted. Physicians were notified per guidelines. 2. All resident have the potential to be effected by the alleged deficient practice. Current residents' MAR's will be reviewed for the last 30 days, any deficiencies noted were corrected at that time. No negative outcomes were noted. 3. Licensed staff will be in-serviced on following guidelines for medication administration and ensuring of following physician orders. 4. The DHS or designee will monitor medication administration randomly of three nurses per week for 6 months covering all shifts. The DHS or designee will report findings to the QA Committee monthly for 6 months and, if necessary, the QA Committee will expand the audit until 100% compliance is obtained.	03/23/2012

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	medications were set up. She then informed the resident of each pill she was giving to her. Resident #86 informed LPN #30 she gets two tablets of the potassium. LPN #30 asked the resident if she usually gets two tablets of the potassium and the resident indicated she did. LPN #30 then left the room and looked at the medication sheet again and obtained another potassium tablet for the resident. The resident's Medication Administration Record (MAR), dated 02/12, indicated an order for Potassium 10 meq, give two capsules (20 meq) daily. The resident's physician's recapitulation orders, dated 02/12, indicated an order dated 07/05/11, for potassium 10 meq, give two capsules (20 meq) daily. 2. During a medication administration observation on 02/15/12 at 8:40 a.m., LPN employee #30 prepared Resident #88's morning medications, which included Docusate Sodium (laxative) 100 mg (milligrams), two daily. LPN #30 placed one capsule of Docusate Sodium in the plastic medication cup. LPN #30 then entered Resident #88's room to give him his morning			

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	medications. LPN #30 then continued to pass medications to two other residents. During an interview on 02/15/12 at 9:17 a.m., LPN #30 indicated the resident was supposed to receive two capsules of Docusate Sodium. She indicated she had given the resident one capsule. The resident's MAR, dated 02/12, indicated to give Docusate Sodium 100 mg, two capsules daily. The physician's recapitulation orders, dated 02/12, indicated an order, dated 09/07/11, for Docusate Sodium 100 mg, two capsules daily. 3. Resident #114's record was reviewed on 02/14/12 at 10:05 a.m. The resident's diagnosis included, but was not limited to, vascular dementia. The resident was admitted into the facility on 02/06/12. The resident's physician's orders, dated 02/06/12, indicated an order for the following supplements: Vitamin B6 25 mg (milligrams), Folate 800 mcg (micrograms), Vitamin B12 400 mg twice a day. The resident's Medication Administration Record (MAR), date 02/12, indicated by initials with circle around them, the			

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	supplements were not given twice a day as ordered from 02/07/11 through 02/14/11. During an interview on 02/14/12 at 10:20 a.m., LPN employee #37 indicated the resident had not been receiving the supplements. 4. Resident #95's record was reviewed on 02/15/12 at 2 p.m. The resident's diagnoses included but were not limited to diabetes mellitus and macular degeneration. The physician's recapitulation orders, dated 02/12, indicated an order, dated 08/22/11, to check the resident's blood sugar before meals and at bedtime and to give Humulin Regular insulin dose is determined by blood sugar result (sliding scale). The 01/12 physician's recapitulation orders indicated the following regular insulin doses: 150-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units The resident's MAR, dated 01/12 indicated the resident's blood sugars were			

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	not obtained on 01/03/12 at 4 p.m. and 9 p.m., or 01/12 at 6 a.m. The resident's MAR, dated 02/12, indicated the resident's blood sugars were not obtained on 02/08/12 at 4 p.m. and 9 p.m. During an interview on 02/15/12 at 2:15 p.m., the ADoN indicated the blood sugars had not been completed. The resident's MAR, dated 01/12, indicated on 01/14/12 at 9 p.m., the resident's blood sugar was 201 and the resident received two units of insulin. The MAR indicated on 01/30/12, the residents 4 p.m. blood sugar was 218 and the resident received two units of insulin. During an interview on 02/15/12 at 2:30 p.m., the Residential Unit Manager indicated the resident should have received four units of regular insulin on 01/14/12 at 9 p.m. and 01/30/12 at 4 p.m.			

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R0298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interview, the facility failed to ensure the Pharmacist reviewed a resident's drug regimen at least once every 60 days for 1 of 7 residents reviewed for drug regimen review in a total sample of 7. (Resident #85) Findings include: Resident #85's record was reviewed on 02/14/12 at 11:45 a.m. The resident's diagnoses included, but were not limited to chronic pain and laryngeal cancer. The resident's last admission date into the facility was 10/24/10. Review of the physician's recapitulation orders, dated 02/12, 01/12, and 12/11,	R0298	1. The Pharmaceutical consultant was called during survey to set up a time to review resident #85's records. 2. All residents have the potential to be at risk. All residents records were reviewed and any deficiencies noted were corrected at that time. No negative outcomes were noted to any resident. 3. DHS or designee will audit all records monthly to ensure the Pharmacy consultant has reviewed the resident's record to meet the guidelines. DHS or designee will monitor records monthly to ensure recommendation are completed and followed up. 4. DHS or designee will report findings to the QA Committee monthly for a period of 6 months and, if necessary, the QA Committee will expand the audit until 100% compliance is	03/23/2012

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	lacked documentation to indicate the pharmacist had reviewed the resident's drug regimen every 60 days. There was a lack of documentation to indicate the pharmacist had reviewed the resident's drug regimen in the resident's record. During an interview on 02/15/12 at 1:40 p.m., the Assistant Director of Nursing indicated the Pharmacist had not reviewed the resident's drug regimen every 60 days.		obtained.	

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R0356	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure a resident had a current emergency information file for 1 of 5 residents reviewed for emergency files in a total sample of 7. (Resident #114) Findings include: Resident #114's record was reviewed on 02/14/12 at 10:05 a.m. The resident's diagnosis included, but was not limited to, vascular dementia. The resident was admitted into the facility on 02/06/12. The three ring binder at the Nurses'	R0356	1. Resident #114 emergency record was updated during the survey. 2. All residents have the potential to be effected by the alleged deficient practice. Residents records were reviewed and any deficiencies noted were corrected at that time. No negative outcomes were noted to any resident. 3. DHS or designee will completed emergency records for all residents. DHS or designee will completed emergency records on all new admissions. 4. DHS or designee will audit monthly to ensure guidelines are being met. DHS or designee will report findings to the QA Committee monthly for 6 months and, if necessary, the QA	03/23/2012

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	Station, which was identified by the Legacy Unit Director, as containing the resident's emergency files on 02/14/12 at 10 a.m., lacked documentation of emergency information for Resident #114. During an interview on 02/14/12 at 10 a.m., the Legacy Unit Director indicated there was not an emergency file for Resident #114.		Committee will expand the audit until 100% compliance is obtained.	

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R0409	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure a resident had a yearly statement from the physician to indicate the resident was free of communicable diseases including tuberculosis in an infectious stage for 1 of 7 residents reviewed for an annual health statement in a sample of 7. (Resident #85) Findings include: Resident #85's record was reviewed on 02/14/12 at 11:45 a.m. The resident's diagnoses included, but were not limited to chronic pain and laryngeal cancer. The resident's last admission date into the facility was 10/24/10. The resident's file lacked documentation of a yearly health statement by the physician to indicate the resident was free of communicable disease including tuberculosis in an infectious stage. During an interview on 02/15/12 at 1:40	R0409	1. Resident # 85 health statement was completed during survey. 2. All residents have potential to be effected by the alleged deficient practice. Residents records were reviewed any deficiencies noted were corrected at that time. No negative outcomes were noted to any resident. 3. DHS or designee will ensure the Health statement will be completed on admission and annually thereafter. DHS or designee will audit all charts and any record lacking a Health Statement will be completed by the attending physician. 4. DHS or designee will audit monthly for 6 months to ensure the guideline is met. DHS or designee will report findings to the QA Committee monthly for 6 months and, if necessary, the QA Committee will expand the audit until 100% compliance is obtained.	03/23/2012

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	p.m., the Assistant Director of Nursing indicated there was no annual health statement in the resident's medical record.			

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R0410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure resident's received a yearly Mantoux (test for tuberculosis) for 2 of 7 residents reviewed for yearly Mantoux's in a total sample of 7. (Residents #85 and #86) Findings include: 1. Resident #85's record was reviewed on 02/14/12 at 11:45 a.m. The resident's diagnoses included, but were not limited to chronic pain and laryngeal cancer.	R0410	1. Resident # 85 & # 86 TB were administered during the survey. 2. All resident have the potential to be effective. Medical records were reviewed any deficiencies noted were corrected at that time. No negative outcomes were noted for any resident.3. DHS or designee will develop a master TB list of when residents are due to annual testing. The DHS or designee will ensure the TBs are being administered and read accordingly. 4. The DHS or designee will audit medical records monthly to ensure the guideline is being met. The DHS or designee will present findings	03/23/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	02/22/2012

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	The resident's last admission date into the facility was 10/24/10. The resident's last documented Mantoux testing was completed on 11/19/10. There was a lack of documentation to indicate the resident received a yearly Mantoux annually in 2011. During an interview on 02/15/12 at 1:40 p.m., the Assistant Director of Nursing indicated a yearly Mantoux had not been completed. 2. Resident #86's record was reviewed on 02/14/12 at 11:25 a.m. The resident's diagnoses included, but were not limited to, hypertension and dementia. The last documented Mantoux in the medical record was dated 07/24/10. There was a lack of documentation to indicate the resident had a yearly Mantoux test given since 07/24/10. During an interview on 12/15/12 at 11:50 a.m., the Assistant Director of Nursing indicated there was no other yearly Mantoux given to the resident.		to the QA Committee monthly for 6 months and, if necessary, the QA Committee will expand the audit until 100% compliance is obtained.	

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